ARIZONA BOARD OF OCCUPATIONAL THERAPY EXAMINERS
5060 North 19th Avenue, Suite 209
Phoenix, Arizona 85015
(602) 589-8352
FAX: (602) 589-8354
www.mindspring.com/~abote
azot@mindspring.com

PROFESSIONAL RECOMMENDATION FORM

This Professional Recommendation Form must be completed, signed and submitted by a licensed Medical or Medical Service Professional.

(PLEASE PRINT OR TYPE)

The applicant portion of this form should be completed by the individual who is seeking an Occupational Therapist, Occupational Therapy Assistant license or a Limited Permit.

1. APPLICANT

Name: _____(_____)
First Middle Initial Last Other Names Used

Mailing Address: _____
Street Address Apt# City State Zip Code

National Board for Certification in Occupational Therapy (NBCOT) certification number: _____

The remaining portion of this Professional Recommendation Form must be prepared, signed and personally dated by the Medical Service Professional submitting the form on behalf of the applicant.

2. MEDICAL OR MEDICAL SERVICE PROFESSIONAL

a. Please provide the following information:

(1) Where the person making the recommendation worked with the applicant.

_____

_____

(2) A written narrative describing the professional relationship or professional experience with the applicant and why they recommend **OR** do not recommend the applicant for an Occupational Therapy license:

(a) I do hereby recommend this applicant _____ (Provide written narrative).

_____

_____

_____

_____

(b) I do <u>not</u> recommend this applicant _____ (Provide written narrative).

_____

_____

_____

_____

(3) What is the length of time that you have known this applicant? _____ Years _____ Months

(4) What is the length of time you have worked with this applicant? _____ Years _____ Months

(5) Would you consider this applicant to be of good moral character? _____ Yes _____ No

b. Please provide the following information concerning the Medical or Medical Service Professional completing, signing and submitting this form on behalf of the applicant:

(1) My name and address are:

_____
First Name Middle Initial or Name Last Name

_____
Street Address Apt/Suite # City State Zip Code

(2) My daytime telephone number is: ( ) _____ - _____

(3) My professional license or certification title, license or certification number is:

_____
Title Number

(4) Name of the State or Federal agency who issued my professional license or certificate is:

_____

3. SIGNATURE & DATE SIGNED BY THE MEDICAL OR MEDICAL SERVICE PROFESSIONAL WHO PREPARED AND IS SUBMITTING THIS PROFESSIONAL RECOMMENDATION FORM.

_____ _____
Signature Date

(PLEASE RETURN WITHIN 10 DAYS)
NO FAXED FORMS WILL BE ACCEPTED!